REQUEST FOR APPLICATIONS (RFA) CHA-RFA-110609

District of Columbia
Department of Health
Community Health Administration

Chronic Care Initiative – Second Cycle

Invites the Submission of Applications for Funding under the District of Columbia Department of Health, Community Health Administration, Chronic Care Initiative Request for Application. Authorization (Legislation/Regulation) (1) Community Access to Care Amendment Act of 2006 (DC), and (2) Part A, Title XIX, Section 1901-1909, Public Health Services Act (Public Law 102-531), as Amended.

Announcement Date:	**November 6, 2009**
RFA Release Date:	**November 6, 2009**

(Optional) Pre-Application Conference November 12, 2009, 2-4pm

Optional Notice of Intent to Apply Deadline: November 20, 2009, 4:45pm.

Application Submission Deadline: Tuesday, December 7, 2009 4:00 p.m.

LATE APPLICATIONS WILL NOT BE FORWARDED TO THE REVIEW PANEL

"N O T I C E"

PRE-APPLICATION CONFERENCES

WHEN: Thursday, November 12, 2009- 2:00pm to 4:00pm in Room 4131

WHERE: **Department of Health**
Union Square
825 North Capitol Street, N.E.
4th Floor, Room 4131
Washington, DC 20002

CONTACT PERSON: Charles Nichols
Department of Health
825 North Capitol St., NE
Third Floor, Room 3137
Washington, DC 20002
Phone: 202-442-9342
Fax: 202-442-4796
charles.nichols@dc.gov

"N O T I C E"
OPTIONAL INTENT TO APPLY

APPLICANTS **ARE ENCOURAGED** TO COMPLETE A "NOTICE OF INTENT TO APPLY" FORM FOUND IN THIS PACKET AND SUBMIT IT AS INSTRUCTED BY **FRIDAY, NOVEMBER 20, 2009, at 4:45pm**. THIS WILL ASSIST DOH TO ARRANGE FOR REVIEW IN A TIMELY WAY.

CONTACT PERSON:

Charles Nichols
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825 North Capitol St., NE
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OPTIONAL NOTICE - INTENT TO APPLY **CHA-RFA-110609**
Please complete this form and fax or mail it, or send the same information by Email to

Charles Nichols
Department of Health
825 North Capitol St., NE
Third Floor, Room 3137
Washington, DC 20002
Phone: 202-442-9342
Fax: 202-442-4796
charles.nichols@dc.gov

Contact Name_____

Organization _____

Street address _____

_____

Email _____

Telephone(s) _____

In order to help DOH ensure that outside reviewers have no conflict of interest, please name all organizations that are part of this application (as partners in the team or sub-grantees, and anyone who is to be a consultant.) You do not need to list clinical service providers in Washington, DC (because they will be assumed to be involved in spreading useful changes and therefore might have conflicts of interest in reviewing applications)

Checklist for Applications

- ❑ This application is separate and complete in itself. If the applicant has submitted multiple applications for different sections of this RFA or for more than one intervention project, each must be entirely separate and complete in itself.
- ❑ The applicant organization/entity has responded to all information required in the relevant section of the Request for Applications.
- ❑ The Applicant Profile, found in Attachment A, contains all the information requested.
- ❑ The Application includes an official transmittal letter signed by an authorized representative of the applicant.
- ❑ The Program Budget is complete and complies with the Budget forms listed in Attachment F of the RFA. The budget narrative is complete and describes the categories of items proposed.
- ❑ The application is printed on 8½ by 11-inch paper, **double-spaced**, **on one side**, **using 12-point type with a minimum of one inch margins**.
- ❑ The application summary section is complete and is within the one-page limit.
- ❑ The project description section is complete and is within the 25-page limit.
- ❑ The applicant is submitting one (1) original, one electronic copy (on disc or flash drive) and five (5) paper copies of its application. (If there is more than one application from an applicant, each set is to be packaged separately.)
- ❑ The application format conforms to the "Application Format" listed on page 15 of the RFA.
- ❑ The Certifications and Assurances listed in Attachments B and C are complete and contain the requested information.
- ❑ The appropriate appendices, including program descriptions, staff qualifications, individual resumes, licenses (if applicable), and other supporting documentation are enclosed.
- ❑ The application is submitted to **DOH, 3rd Floor, Office of Grants Management, Room 3137** no later than 4:00 p.m., on the deadline date of **Monday, December 7, 2009.**
- ❑ The application is submitted with **two original receipts**, found in Attachment G, attached to the outside of the envelopes or packages for **DOH** approval upon receipt.
- ❑ Appendices are included in the application submission.

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District of Columbia
Department of Health
Community Health Administration

REQUEST FOR APPLICATIONS CHA-RFA-110609

CHRONIC CARE INITIATIVE – SECOND CYCLE

SECTION I - GENERAL INFORMATION

Overview of the Initiative and this Application Process

Washington, DC has substantial challenges in optimally supporting residents who are living with chronic conditions. Certain chronic conditions are common causes of death and also interrelate by having common causes: cardio-vascular disease, diabetes, chronic kidney disease, stroke, hypertension, and chronic obstructive lung disease. Most people who live with one of these eventually have to live with more than one. Optimal service delivery would, for example, assure self-care education, rapid response to worsening status, aggressive reduction of risk factors to delay progression, relief of symptoms, advance care planning, and modification of the illness through medical interventions when appropriate. Usual care, in contrast, shows substantial shortcomings on each of these elements, with patients often not understanding their condition(s) or the benefits of self-care, with errors in medication management (especially at the time of changes in setting of care), with clinicians not paying attention to achieving targets for clinical care and prevention, and with repeated (avoidable) hospitalizations. The available evidence underscores that our city has both very high expenditures on health services and unreliable quality across time. These conditions have origins in our city's health habits as well as our genetics, nutrition, exercise, reducing tobacco use, screening for risks, and early intervention on risks or pre-clinical disease have a strong role in reducing the burden of these chronic conditions.

In 2009 the Department of Health funded twelve projects using almost half of the $10 million that was set aside by the Council of the District of Columbia for chronic disease management of fatal illnesses. The aim is to build an enduring improvement initiative that will guide our city's service delivery toward high-reliability, high-value, and high-quality care. (See Attachment J) The Chronic Care Initiative (CCI) was built upon observations such as these:

- The shortcomings mostly arise from the way that service delivery is organized rather than from lack of expertise or dedication among our clinicians.
- Chronic conditions require continuity of plans across settings and time, a process that is not often available to most patients.
- All affected residents deserve high-value, high quality care, and special attention will be required for those who face more substantial barriers than others.
- High-value service delivery will require simultaneous changes in many sectors, including information exchange, payment patterns, and priorities in evaluating quality.

- Very little prior experience guides the process of geographically-based service delivery reform -- successful reports are mostly in small or controlled environments. Thus, we will need to generate substantial insights during the process.
- Changes should be continuously guided by evidence, and priorities should be reset periodically.

The first group of projects started in spring-summer 2009, so the track record is not long. The teams have participated in three Learning Sessions and have learned to collaborate among themselves to solve problems efficiently. The grantees have brought themselves and others to form an energetic new organization, the Chronic Care Coalition, intending to use that forum to consider priorities and options and to engender data and analyses to guide ongoing improvement. Many of the teams have tried out their first few tests of changes and have started to learn what data guides change and what changes can be effective. Some teams have reached out to involve critical new members. Coaches from DCPCA have been helpful in teaching methods, and support for meetings, communication, measurement, and networking has been provided by United Medical Center Foundation. The projects in the first group funded are listed in Attachment J.

During the second cycle of funding, the Department will support an additional array of improvement projects. The interventions to be tested can be drawn from experience reported elsewhere, as well as from insights and pilots generated locally. All intervention projects will have to aim to meet these requirements:

- Have substantial impact on improving the experience of patients and families
- Enhance efficiency
- Plan to test each change, sustain changes that prove to be useful, learn to apply successful changes (proven in one setting) throughout the city, and implement strategies to sustain them
- Learn from informative monitoring and measurement
- Multiple organizations may be involved in each project
- Address the most important chronic care needs of the city's affected residents

The CCI will seek to generate one or more groups that will thoughtfully guide the process, using data and being responsive to the city's needs and priorities. Clinical information exchange (across settings) and openness of the process to the public will have strong roles. The success of the endeavor relies upon having strong and effective improvement strategies to test and implement. Eventually, key elements of the service delivery system such as payment, standards, licensure, and other elements will have to come into alignment, and this CCI will speak to those issues and engage in those processes via the inclusion of our partners in the Department of Health Care Financing and within DOH.

Thus, with this RFA, the District of Columbia Department of Health (DOH), Community Health Administration (CHA), Bureau of Cancer and Chronic Disease (BCCD) announces the second cycle of up to 18 months of funding for a five-year initiative aiming to improve the health outcomes of District residents who face any of six serious chronic conditions by fundamentally

improving the reliability, efficacy, and efficiency of the healthcare services they receive. The six conditions are cardiovascular disease, hypertension, diabetes, chronic kidney disease, stroke, and chronic obstructive lung disease. The overall goals of the initiative are (1) to promote longer and healthier lives through each stage of these illnesses, and (2) to promote/enable the DC healthcare system to deliver highly reliable, evidence based services for persons living with these conditions at the right time and with the lowest possible cost, for all residents of the District of Columbia.

The Initiative aims to engender and support coalitions that will serve as learning organizations to guide ongoing improvement in the public's health and in the value of services provided to persons living with these conditions. The DOH intends to collaborate closely with community partners throughout this work. Grantees should expect to work closely with various city agencies and officials, including those responsible for policy, epidemiology, and evaluation, for information technology, and for public information. The method for most of the work of change will be a general model of continuous quality improvement, with formation of learning organizations, setting of goals, testing of options with monitoring of effects, increasing insights about effective improvements, sustaining worthy improvements, making them permanent, and spreading them across the city. The general model of illness will be a bio-psychosocial model, and the general model for service delivery can rely on the Chronic Care Model (http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2).

In addition, intervention activities that directly aim to change service patterns and practices will sometimes be supported by multiple grants, running simultaneously. If one organization is applying for more than one Intervention application, EACH APPLICATION MUST BE COMPLETE, be submitted in a separate package, and contain all elements requested in this RFA including a separate budget and assurances. In order to encourage broad participation in this improvement activity, current projects and lead personnel may not apply for additional funding in this initiative. Different projects or different lead personnel from the same organizations may apply, and existing projects can be sub-grantee mentors if another organization within DC proposes to spread and help sustain work that the current grantee has shown to be promising. However, only one application may be submitted from a current grantee organization, while other organizations could submit two different applications.

While the CCI targets widespread and important conditions that are interrelated, it does not target many other important conditions. Nevertheless, the work of redesigning service patterns should generalize to similarly ill persons facing other conditions, and adequate services for many of these patients will require dealing with common co-morbidities such as depression, disability, and arthritis. For example, projects may have to improve arthritis in order to increase exercise for diabetics, or to increase the availability of medical services at home for seriously ill and disabled persons generally, in order to have them available to residents who are in the CCI's target group.

The DOH is especially concerned for those who are disadvantaged in health and health care services, especially the poor, racial and cultural minorities, residents of Wards 7 and 8, and persons living with challenges associated with mental illness or substance abuse.

DOH expects to announce a third round of competition for grant support in about six months (mid-2010). The later round of grant support is expected to make modifications in the "infrastructure" grants to accommodate demonstrated needs and to reflect performance. By the third round, highly collaborative projects across multiple providers or community-based organizations may also become central to the work.

Various resource documents that may be of use to applicants, grantees, and participants in the CCI are now stored on the DOH website for easy access: www.doh.dc.gov (readers can click on "Chronic Care Initiative" under "Information" on the left.)

Existing funding in the Chronic Care Initiative supports coaching and training in quality improvement methods, provided by staff from the DC Primary Care Association (DCPCA). There will be a specific training opportunity available during the period of application preparation. The next training and coaching day will be held on November 19, 2009. Please send an email to Gwendolyn Young, Program Performance Manager, gyoung@dcpca.org to obtain information and communicate directly with DCPCA about any arrangements. There will also be an opportunity to sign up for this support at the pre-application conference on November 12, 2009. The aim is to help all applicants to understand these resources on methods and community coalitions. The CCI also supports networking and the formation of a Chronic Care Coalition (CCC) that has become quite active in learning about the challenges of chronic conditions in DC and that has an array of working teams and committees. Information regarding the CCC may be obtained by contacting the United Medical Center Foundation (UMCF)-Calvin Smith 202/574-5432/Email-CLSmith@United-MedicalCenter.com and Steven Hornberger 301/270/0882/Email-shornberger@ltgassociates.com.

Focus Areas for Consideration

These areas were not a focus of any projects in the first round of funding. DOH presents this list for consideration, but applications are welcome that address any target problem where correcting the problem will likely have a substantial impact upon health of persons at risk of or living with serious chronic disease as defined in this RFA,

1. The initially funded intervention grantees in the Chronic Care Initiative did not include any projects with a focus on the following:
    a. Chronic obstructive lung disease or chronic kidney disease ;
    b. Anchored in entities based in Ward 7 or 8;
    c. Anchored in a community-based organization, ANC, or public interest advocacy organization;
    d. Targeting early risk factors, such as smoking; or
    e. Focused upon elderly and/or disabled persons.
2. The initial applications did not include much of the following high-leverage methods.
    a. Involving patients and other directly affected parties directly in the decision-making for the project, e.g., as part of the guiding team;
    b. Timely and highly informative measurement of the merits of intervention implementation, e.g., with a registry; or

c. Sponsoring collaboration among a city-wide group dedicated to spread of a proven improvement strategy, adapted to their needs through ongoing CQI.

Eligible Organizations/Entities
The following are eligible organizations/entities who can apply for grant funds under this RFA:

- Private non-profit entities, including community development corporations, community action agencies, clinical service providers, and community-based and faith-based organizations.
- Current projects and current lead personnel are not eligible to apply for additional supplemental funding under this RFA.
- Organizations funded under Round 1 are only permitted to submit one application in response to this RFA.
- Organizations not funded under Round 1 may submit up to two applications.

Individuals and for-profit entities are not eligible. However, individuals and for-profit entities may be consultants or sub-grantees. In the case of coalitions, one legal entity must take the lead and be legally responsible for the project and the funding. There will be a preference for entities with legal place of business in Washington, DC.

Source of Grant Funding
The funding for this RFA arises from the city's "Tobacco Settlement Funds."

> The District of Columbia's Department of Health has been charged by the Mayor with administering the Community Health Care Financing Fund created from the sale of Tobacco Settlement Asset-Backed Bonds.

These funds expire on July 31, 2011. All funds must be actually paid out by that date. This will require attention on the part of the grantee to be ready to invoice for all services by August 1, 2011.

Award Period
The program period shall extend no longer than July 31, 2011.The projects should propose an appropriate time-frame that matches the work proposed.

No obligation or commitment of funds will be allowed beyond the grant period of performance. Grant awards with periods of performance longer than a year are reviewed and renewed annually, contingent on demonstrated progress by the recipient in achieving performance objectives and contingent upon availability of funds. CHA reserves the right to make partial awards (i.e. partial funding and/or proposed services) and to fund more than one entity for each activity.

Grant Awards and Amounts
A total of $ 3.5 million in District grant funds is anticipated to be available for awards in response to this RFA to support the second cycle of awards. The number and size of awards in

this second cycle are contingent upon the quality of applications and the balance and quality of the projects proposed. **The amounts and number of awards are contingent upon a number of factors and these estimates are given only as general guidance.**

Program Area		Initial estimate	Approximate Number of Awards
1	Improvement projects	$3.5 M over an 18 month period, with options and contingencies	12 Awards (Approximately)

All work using awarded funds must be performed under a current and approved work plan. DOH will monitor fund use, and all funds provided must be used as planned and approved.

Awards may not be used to supplant funds earned by providers through conventional health care insurance, Medicare, Medicaid, the D.C. Healthcare Alliance, or any other program within the D.C. Department of Health or other DC government agencies. These funds are to be used to catalyze important improvements in the process of care. Thus, using them for start-up and testing, monitoring results, spreading better practices, and enabling coalition work will generally be appropriate; however, using these funds for direct services will generally not be appropriate (except for short-term trial or pilot tests). These are not funds intended for use in temporarily meeting a gap in service delivery, but rather for use in changing the mode of service delivery permanently.

In order to be considered for more than one project, applicants must submit separate applications for each. Each application must stand on its own for purposes of competitive evaluation. If there are likely to be efficiencies by having more than one element funded (e.g., by having two interventions funded that use the same measurement strategy), the applicant is encouraged to note that in each application, and the negotiation over work plan and final budget can take those efficiencies into account. DOH reserves the right to make partial awards and to fund more than one agency for each program area.

CONTACT PERSON:

Charles Nichols
Department of Health
825 North Capitol St., NE
3rd Floor, Room 3137
Washington, DC 20002
Phone: 202-442-9342
Fax: 202-442-4796
charles.nichols@dc.gov

No matter how a potential applicant received this RFA, all potential applicants should send an email to charles.nichols@dc.gov with "Chronic Care Initiative" in the subject line and the following information:

- Name of Organization

- Key Contact
- Mailing Address
- Telephone and Fax Number
- E-mail Address

This information will be used to provide updates and/or addenda to this Chronic Care Initiative Program RFA. If a potential applicant does not have access to email, use the phone, fax, or regular mail information to contact Charles Nichols that is given above.

Pre-Application Conference

The Pre-Application Conference will be held on **Thursday, November 12, 2009, 2:00pm to 4:00pm in Room 4131** at 825 N. Capitol Street, N.E., Washington, DC, 20002. Time will be available for asking questions of the DOH/CHA/BCCD and for networking among interested parties. The conference will be

Explanations to Prospective Recipients
Recipients are encouraged to e-mail, mail or fax their questions to Charles Nichols before the COB November 23, 2009. Please allow ample time for mail to be received prior to the deadline date.

SECTION II - SUBMISSION OF APPLICATIONS

Application Identification
A total of six (6) copies of the application and one electronic version are to be submitted in one envelope or package. Two copies of **Attachment D** (Original Receipt) should be affixed to the outside of the envelope or package. **One (1) original and five (5) copies of the application must be submitted. DOH will not forward the application to the review panel if the applicant fails to submit the required six (6) applications and one electronic version. The electronic version may be on a PC-readable disc or a flash drive.** Telephonic, telegraphic and facsimile submissions **will not be accepted**.

Application Submission Date and Time
Applications are due no later than **4:00 p.m**., EST, on **Monday, December 7, 2009.** All applications will be recorded upon receipt. Applications **tendered at or after 4:01 p.m., EST December 7, 2009 will not be forwarded to the review panel for funding consideration**. Any additions or deletions to an application will not be accepted after the deadline of **4:00 p.m. December 7, 2009.**

The six (6) copies of the application and the one electronic version **must be** delivered to the following location:

District of Columbia, Department of Health

825 North Capitol Street, NE

3rd Floor, Room 3137
Washington, D.C. 20002
Attention: Charles Nichols

Mail/Courier/Messenger Delivery
Applications that are mailed or delivered by Messenger/Courier services must be sent in sufficient time to be received by the **4:00 p.m. EST deadline on Monday December 7, 2009** at the receiving location. Applications arriving via messenger/courier services after the posted deadline of **4:00 p.m., December 7, 2009,** will not be forwarded to the review panel by the DOH. NOTE: The office to which recipients are delivering application packages is located in a secured building. Applicants should allow sufficient time to get through building security DOH will not accept responsibility for delays in delivery of applications. **LATE APPLICATIONS WILL NOT BE FORWARDED TO THE REVIEW PANEL.**

SECTION III - PROGRAM AND ADMINISTRATIVE REQUIREMENTS

Use of Funds
Recipients shall only use grant funds for activities included in an approved work plan, which will be revised as warranted by the implementation findings. For example, a work plan might propose to implement three (3) interventions to improve self-care education in a particular group of settings over the coming three (3) months. The initial work plan might plan to build the next work plan on the basis of the findings from that set of experiences. However, experience with the first intervention to be tried might illuminate opportunities or barriers that make even the initial plan imprudent, at which time the project would propose revisions in the work plan earlier than expected.

Direct clinical services require special considerations:

1. All direct clinical services must be billed to insurance first, including Medicaid and Alliance. The CCI funds may not support services for which there is an existing line of adequate payment.
2. Clinical services should be part of the budget only for as long as will be necessary to prove a concept and move toward sustainable funding. These funds are not intended to provide ongoing support or gap-filling payment for clinical services in any other circumstance.
3. The payment rates in Medicare fee-for-service will be presumed to be adequate payment for any clinical services covered by grant funds.

Indirect Cost Allowance
Recipients' budget submissions must adhere to a ten-percent **(10%) maximum** for indirect costs for grants under the CCI. All proposed costs must be reflected as either a direct charge to specific budget line items, or as an indirect cost. If an applicant has a federally approved indirect rate, the applicant can make note of that and explicitly put as direct costs those elements which are required to be placed in the indirect rate in federal contracts and grants but which are practically allocable as direct costs of the proposed project. For example, secretarial support could be broken out as a direct cost. The budget that results must adhere to the limit of 10%

maximum for indirect costs. Grantees who propose to manage subgrantees may account for the costs of administering those sub-grants as direct costs, but may not take indirect costs from the pass-through amounts.

SECTION IV - GENERAL PROVISIONS

Insurance
The applicant must be able to show proof of insurance coverage as required by law before receiving funds and at any time during the grant period.

Audits
At any time or times before final payment and three (3) years thereafter, the District may have the applicant's expenditure statements and source documentation audited.

Nondiscrimination in the Delivery of Services
In accordance with Title VI of the Civil Rights Act of 1964 (Public Law 88-352), as amended, no person shall, on the grounds of race, color, religion, nationality, sex, or political opinion, be denied the benefits of, or be subjected to discrimination under, any program activity receiving any of the funds under the CCI.

Use of Funds
Grant funds may be used for authorized purposes under the grant award. Funds to support this grant derive from the Community Health Care Financing Fund. This fund has statutory purposes limited to:

> …directly paying to promote health care and for the delivery of health care related services in the District, including the construction of health care facilities and the operation of health care related programs, or to reimburse any account of the General Fund for its expenditures for these purposes. (See D.C. Official Code § 7-1931(b).

SECTION V - SCOPE OF WORK FOR INTERVENTION PROJECTS

This section lays out the heart of the enterprise: stating patient-centered goals and how to achieve them – eventually for all parts of the city -- and ensuring that improvements are sustained. More information about the CQI method is at www.ihi.org.

Each application shall explicitly state an aim to pursue, a justification for the importance of that aim, a timeframe for accomplishing it, a team of people who will be doing the work and learning from the effort, and at least one way to measure progress. Each application must also address the possibility of sustaining gains and spreading improved practices to serve all similarly situated persons who reside in the District.

The Aim

The interventions should take a strong and innovative approach to improving care for persons living with the six targeted chronic conditions (hypertension, renal failure, cardiovascular disease, chronic obstructive lung disease, diabetes, and stroke). The project's aim shall be stated as something that is obviously of value in itself. Thus, the aim should be something that benefits residents of the city or identified patients. It is not sufficient to state an aim as having implemented a particular strategy or having tested an innovation; those are important, but they are means to achieve the aim. One test of whether the application is pursuing something important is to ask whether achieving it could conceivably be irrelevant (or even harmful). Thus, an aim of telling patients about their medications at the time of hospital discharge is not an optimal aim since it does not make explicit the desired outcome (and might not achieve it). However, ensuring that patients do not make medication errors that increase the risk of relapse or re-hospitalization meets this test and makes for a much better aim. It is possible to have heard a recitation of one's medications and have nothing else well happen – but it is not possible to reduce risky errors in taking medications without improving things for patients. The strategy of educating patients about their medications would be one of a long list of changes to try in order to achieve the aim of reducing risky errors.

Aims should give an explicit time frame – e.g., to reduce the risk of medication errors that cause relapse or re-hospitalization -- within six (6) months.

Aims should effectively state the relevant measure – e.g., to reduce the risk of medication errors that cause relapse or re-hospitalization by at least half of the starting rate, within six months.

Sometimes teams have multiple aims, and that is acceptable. Sometimes teams will find it difficult to structure their concepts in this way, so the CQI support team will be available for coaching to help such teams (including after award). However, since the period of performance is short (about 18 months), teams that already have learned how to manage rapid cycle change will have an advantage.

DOH notes that strong evidence points to substantial opportunities for improvement in such areas as self-care skills, error-free transitions in setting of care, coordinating services, palliative care, delay of and preparation for worsening illness (e.g., in chronic kidney disease before ESRD, or COPD in smokers before serious disability). DOH also notes that the framing of the applications for this initiative requires that the proposing team conceive of their work as "solving a problem" rather than "implementing a program." A grantee might end up implementing a program, but only if that actually does solve the problem, and evidence for solving the problem needs to be generated during the work.

In general, it is better to construct aims that are "stretch" goals – because those require that the team work toward fundamental changes that endure. It is, in general, a weakness to propose small, incremental aims that are sure to be achieved. Those are often "try harder" goals that go away as soon as the funding ends. Stretch goals often require changes in job descriptions, routine measurement of quality, funding streams, or regulations – which are much more difficult

to lose when the funding stops. The evaluation of the project will turn mostly on process measures of going about change in strong ways, and projects will not face adverse evaluations merely because their goals are hard to achieve. Indeed, many teams will keep working toward their goals outside of this funded project and after it ends.

Additional examples of Aims:
We aim to ensure that, within 18 months, 90% of people with diabetes in wards 7 and 8 will have at least three (3) servings of fresh fruit or vegetables at least 5 days per week.

We aim to reduce the rate of re-hospitalization within 30 days of leaving the hospital (after a stroke, heart attack, heart or lung failure exacerbation, or pneumonia) to 2/3 of the starting rate, within two years.

We aim to ensure that every resident of DC who has been hospitalized in DC with chronic obstructive lung disease has their baseline pulmonary function tests and plan of care available immediately to any ER in the city, and to achieve this within 6 months.

We aim to ensure that every person with newly diagnosed diabetes has self-care or caregiver-care education sufficient to manage diet, exercise, and glucose monitoring to a defined level of expertise, within two (2) months of diagnosis, and to have this level of self-care education to at least 90% of the target population within a year.

We aim to cut in half the number of DC residents with undiagnosed mid-range kidney failure, within one year.

Those writing applications will recognize that the aim may continue to mature as the team learns more about the issue, but it cannot be allowed to drift into becoming a much less important aim. Thus, changes in aims have to be approved by the DOH.

The Team
Some group of people has to actually manage the process of change, and that group has to deliberately learn from the trials of changes meant to improve performance. The team should be made up of those responsible for the specific processes or systems as well as those directly involved in delivering care or services to patients or residents (and often the clients themselves). The application needs to outline who that group will be, and how the group will make decisions and to whom it may expand. This group can be expected to change over time, and reports of those changes will be part of the quarterly report, but DOH does not have to approve changes (in advance or in retrospect).

The application must have a specific institution that will be the grantee, and a specific person who will be the responsible party for the project. Changes in the grantee or the responsible person will require DOH approval before implementation.

Teams may involve people from multiple provider or community-based organizations. The applicant should evidence wisdom in determining who should be on the team, how large it

should be, and how to involve people who are important for success but not working on the team.

In many countries, teams tackling clinical or life-style problems routinely include patients or their families. Applicant should consider whether and how to obtain input and engagement from patients and families.

Examples of Teams*:*
The key clinical personnel from a hospital, nursing home, home care agency, and hospice who regularly provide care to a shared group of patients would be appropriate for a project to optimize transitions.

Community-based groups from around the city might cooperate in a team to improve exercise opportunities for people with diabetes.

A coalition of clinical service providers serving Latinos might work together to reduce re-hospitalizations of Latino patients with fragile health.

The Changes to Test
Some projects will have a well-proven change for which the challenge is how to get it widely deployed; others will have a substantially challenging situation for which a long list of changes might work, though none are well-established. All sorts of combinations can arise. However, in general, the teams should be more tightly allegiant to their aim than to the specific changes. Usually, there are multiple ways to make changes, and all of them usually require testing and adaptation in order to be optimally effective and to be sustainable. Thus, this section should be clear as to how the team expects to start and how they would know whether their first changes are worth continuing – but the later changes might still be mainly a list of good ideas that might, or might not, be tested and implemented, depending upon what the team learns early on. Changes to try can often arise from the written experience of others (e.g., in the professional literature) or pilot tests here, or even just from the hunches and observations of experienced people who are engaged in the issues. When changes are novel, they will need to be written down, along with a thoughtful consideration of any potential harms and the expert evidence that supports the strategy, and filed with the CQI support grantee (DCPCA) which will advise DOH on acceptability before implementation.

Intervention plans should evidence awareness of major initiatives happening in the District outside of the CCI-funded intervention projects. For example, the diabetes self-care education project to reduce disparities being implemented by Delmarva and existing pilots to reduce ER use will affect many potential intervention projects.

Applicants must take note of the importance of assuring that proven improvements can spread across the city, and that they can be sustained after the grant funding stops. The application should provide an explanation of how the sponsors see the process of spread and the issue of sustainability. These plans do not have to be assured, but the team should evidence a commitment to spread and sustainability and should make it plausible that their vision could work.

This RFA does not intend to support research on human subjects. Consider the CDC definition at http://www.cdc.gov/od/science/regs/hrpp/researchDefinition.htm -

> "The major difference between research and non-research lies in the primary intent of the activity. The primary intent of research is to generate or contribute to generalizable knowledge. The primary intent of non-research in public health is to prevent or control disease or injury and improve health, or to improve a public health program or service. Knowledge may be gained in any public health endeavor designed to prevent disease or injury or improve a program or service. In some cases, that knowledge may be generalizable, but the primary intention of the endeavor is to benefit clients participating in a public health program or a population by controlling a health problem in the population from which the information is gathered."

The testing of changes in services to improve efficacy, efficiency, or quality is classified as ordinary operations with quality improvement and projects like this should rarely be constructed as research on human subjects. If a participating institution's policies require that an intervention project be reviewed by their Institutional Review Board (IRB), then the costs and delays associated must be borne by the institution and not by this funding. An application to an IRB, if required, should usually seek affirmation that the proposed project does not entail research on human subjects. (See also http://www.annals.org/cgi/reprint/146/9/666.pdf) DOH may require this review to be complete before funding starts.

Examples of Changes to Test:
Increased and standardized provider reminder systems (chart stickers, vital sign stamps, medical record flow sheets, and checklists)

Standardized/systematized provider education, and feedback on performance (perhaps especially from downstream providers concerning the plan of care and the quality of transitions)

Setting standards among experts - Establishing clinical protocols and best practices

Identifying and reducing barriers to optimal care processes (across settings and time)

Standardized/systematized patient/caregiver education, perhaps at particular trigger points in the care process and including rehearsals, practice and performance, brush-ups

Multidisciplinary teams negotiating care plans with patients and families and documenting goals, plans, and timing of review

Information transmission to patients – honest, timely, desired

Continuity of care – continuity of providers, continuity of care plan, continuity of records

Development of specific registries – e.g., of diabetics, or of persons disabled by advanced illness and living at home

Population-based Interventions

- *Mass messages – e.g., regarding what to expect/demand*
- *Targeted media messages (including educational materials)*
- *Counseling provided outside of health care settings*

Measurement

Improvement and measurement are intertwined. To make meaningful improvements, we must first make changes, then measure those changes and evaluate whether they were improvements. Having a reliable system for measuring change and evaluating the outcome of the change is essential. In a project that is anchored in rapid cycle quality improvement, measurement is intrinsic to the process. Learning what works requires a way to monitor progress, so each application will need to articulate a plan for measurement of at least their initial tests and their overall aim. These generally will use annotated time series, though designs that include comparison groups or other more rigorous designs will also be welcome. However, randomization to improve the strength of inference is not acceptable, since that is a marker of research on human subjects. Randomization that is an equitable response to limited supply, allowing comparison to wait lists, may be useful in some situations (see discussion of differentiation of CQI from research above in this section). Evidence that the teams have thought through sampling and data collection strategies that are sufficient to guide their work will buttress the strength of an application. However, the CQI technical support team (at DCPCA) will be available to help by consulting before or after a grant award. If the team is going to want ongoing help with measurement issues, including data collection and/or analyses, the application responding to this RFA should articulate the anticipated needs. If the application receives a grant, then the support needed will be part of the support grantee's (DCPCA's) work plan and budget.

Many projects require more than one measure, and often it is appropriate to monitor the possibility of an adverse effect as well as monitoring the desired effect. Sometimes one measurement strategy addresses the overall aim and is continuous throughout the project, while measurement of implementation of a change might be done only for a short time.

In general, the most useful measurement strategy is to prepare one or more time series showing trends. Given the short time-frame (18 months), it is an advantage to implement time series measurements that can be reported relatively frequently and relatively quickly – thus, surveying current patients enough to have a data point each week will teach the team more about the effects of a change than having a mailed survey once a quarter. Usually, a time series has a percentage on the Y axis and a series of dates on the X axis.

Examples of measurement strategies

Make phone calls to a sample of recently diagnosed heart failure patients one week after discharge from the hospital to test their self-care knowledge.
Measure: Percent of patients each week who correctly identify the medications prescribed at discharge one week after discharge.

Check claims for office visit or home care visit within the first week of being at home after a hospitalization with a targeted illness (and before any ER or hospital use).

Measure: Percent of discharged patients each week who have had an office visit or a home care visit within one week of discharge.

Ask a sample of patients to report their own confidence in medication management (see the care transitions measure at http://www.caretransitions.org/ctm_main.asp).
*Measure (example): "*When I left the hospital, I had a good understanding of my health condition and what makes it better or worse." *Weekly percentage who answered "true."*

About Aims, Measures and Changes to Test

This CCI is open to having a broad range of aims and changes, of varying length and with different kinds of teams. The examples given in this RFA do not limit the scope. There are some areas that would be desirable for balance and impact, and these are listed below and given a small additional scoring advantage in the review process. This second cycle of funding will have only a limited number of funded intervention projects and these must be ready to proceed quickly, without needing a great deal of support from the infrastructure grantees. Applicants should seek funding for projects that match their commitments and the maturity of their project and should be frugal in budgeting. The review process will be attentive to the value of the likely project in relation to the funding needed.

Applicants should remember that the funding for interventions should be catalytic, not mainly aimed at providing services. These funds should support measurement, start-up costs, learning from trials, and pilot projects. They should not be used for meeting a clinical need for a short time.

The aim, team, changes, and measurement strategies must all mesh. Thus, the measurement needs to be intrinsic to the aim, the changes proposed must be likely to accomplish the aim, the team must have control over the opportunity to make changes, and so forth.

This CCI is intended to generate lasting changes, including the continuing method for ongoing improvement. **Thus, every intervention project must address opportunity for sustaining the gains and ensuring spread of successful strategies throughout the city.** The Department of Health Care Financing (DCHCF) is aware of this CCI and is ready to collaborate in exploring how to align payment with good practices. Teams should have other strategies as well, and they should carefully consider what actions local or Medicare financing could reasonably undertake and how long that would require. A general claim of sustaining the gains by obtaining more city funding, new health care services payments, or private philanthropy will not be persuasive in the review process.

In writing the application, the AIM, TEAM, MEASURE, CHANGES, and "SUSTAINABILITY AND SPREAD" must be explicitly stated and labeled as such. Each should be presented, explained, and justified. See the structure below.

SECTION VI – MONITORING AND EVALUTION OF PROJECTS DURING THE GRANT PERIOD

The grantee should propose in the draft workplan (Attachment D) a set of landmarks of progress that DOH may take to evidence progress toward their goal. These should be constructed to be reported at the end of March 2010 (after only 1-2 months) and then quarterly thereafter. A suggested template that may work for many projects follows:

- By March 31, 2010 – To have the initial team meeting, to have polished the aim, to have the initial measurement fielded, and to have initiated the first change.
- By June 30, 2010 – to have learned something of the merits of the first change and to have at least another change in the field and being measured. To have the first two points on a time-series chart.
- By October 31, 2010 – to have worked up at least one change strategy to the point of knowing that should be implemented widely and sustained, and to have at least two other change strategies under testing. To have at least one time series with at least five data points.
- By December 31, 2010 – to have revised the aim, team, and measure to fit growing knowledge. To have networked with others who can use the growing knowledge. To have at least two change strategies that should be implemented widely and sustained, and to have at least three other change strategies under testing. To have at least one time series that relates closely to the aim with at least five data points. To have developed a plan for sustaining and/or spreading at least one change strategy.
- By March 31, 2011 – to have all of the above, plus implementing the plan and extending the time series. And evidence of making convincing progress on the overall aim (be specific on what this would be)
- By June 30, 2011 – escalating gains above, and also a solid plan for sustaining gains and continuing to pursue aims.
- By July 31, 2011 – must have all expenditures documented and invoices submitted. In the case of this funding, all payments must be made before the end of August 2011.

Some of the current grantees have found it useful to organize their objectives around the Chronic Care Model, mentioned above.

SECTION VII - REVIEW AND SCORING CRITERIA

Review Panel

The review panel will be composed of neutral, qualified, professional individuals who have been selected for their unique experiences in human services, public health, data analysis, health program planning and evaluation, social services, planning and implementation, and quality improvement for population health. The review panel will each review, score, and rank each application, and when the review panel has completed its review, the panel shall make recommendations to the Director of DOH who will weigh the results of the review panel against other internal and external factors in making the final funding determinations.

SCORING CRITERIA

Applicants' submission will be objectively reviewed against the following specific scoring criteria listed below.

Criterion A	**Statement of Problem, Knowledge and Understanding of the Need To Address**	**Total 20 Points**

In this section the applicant should justify the need for solving the problem proposed for the target population through a demonstration of the applicant's knowledge and understanding of the core capacity areas.

(a)	Present the applicant's knowledge and understanding of the problem, its importance and its impact in population terms. Include a clear statement of the problem and an estimate of the size of the problem – number affected, who they are – and identify the auspicious and difficult aspects of the situation that might shape the project.	**10 points**
(b)	Develop a Driver diagram (SEE Appendix H) to illustrate what drivers sustain this problem and what general kinds of interventions might reduce the force of the main drivers. Then highlight the changes that this project proposes to implement? Provide a narrative explanation of the diagram and how it defines the problem.	**5 points**
(c)	Describe how this project will relate to the city's overall pursuit of reducing the burden of chronic illnesses. The application should identify other initiatives they are aware of that would be pertinent to the success of the proposed project and how they intend to collaborate and share experiences. The applications should also address whether and how they will be attentive to broad chronic disease priorities in public health: tobacco control, and obesity and exercise.	**5 points**

Criterion B	**Theoretical and Technical Soundness of Project**	**Total 55 Points**

This section develops an AIM Statement, how it will be addressed and measured.

(a)	Develop an AIM Statement(s) to guide the project that: i. Proposes a measurable improvement, e.g., assure safe transfers from post-hospital skilled nursing facility stays to home, as evidenced by compliance with a checklist of important elements (or as evidenced	**10 Points**

	by zero defects on a set of patient-centered outcomes); ii. The measurement should be implied in the statement, and it should be plausible and affordable to collect. The project must actually plan to collect the data needed. iii. The aim should be stated in terms that are relevant to the resident, whether a patient, a healthy person, or a family member. For example, say "family caregivers report being well-trained and confident" rather than "training is supplied to family caregivers" or "residents of ANC#X double their rate of average daily consumption of fresh fruits and vegetables" rather than "start up three local markets that will carry fresh fruits and vegetables." Sometimes the "process" is so closely associated with the patient/resident outcome that it is wise to measure and target the process, but then that link must be explicitly articulated in the application. iv. The aim must give a timeframe (e.g., to have 90% of hospital discharge information to arrive at the patient's medical home within 48 hours, within 6 months, or to have 75% of persons living with stage III-IV kidney failure identified and meeting three criteria of high-quality preventive care for more than a year before needing dialysis, achieved within 18 months.) There must be at least one important aim with a timeframe within that will be completed by July 1, 2011. In addition, the application should relate the plan to the overall Triple Aim framework (see www.ihi.org) a. Better "patient" experience (can include keeping healthy people healthy) b. Better population health (can include living longer and better with serious illness and disability) c. Lower per capita cost (can include costs outside of traditional "medical" care, of course)	
(b)	2. Team a. Identify the initial team, including any future modifications needed.	**5 Points**

	b. Propose how you will evaluate and modify the team over time. c. Propose how the team will relate to existing elements in their working environment – providers, consumer groups, funders, etc. and if you will need multiple teams to test concepts with different elements. There may be more than one aim if they are closely related or logically sequential.	
(c)	Methodology Identify the methods you intend to use. All projects will use evidence-guided tests of change, and thus will be using some form of quality improvement to attain your aim with attention to spread and sustainability. A couple of examples include you might focus on organizing and informing a relevant community (perhaps for simultaneous or future improvement activity); or managing and understanding resource use (e.g., payment policies). Other methods are possible, of course, but the methods envisioned must be explicitly stated.	**5 Points**
(d)	Workplan (Attachment D) Applicant develops an initial workplan with timelines and responsible staff on how the plan will achieve the aim(s), matches the measure(s) to the aim(s). Includes measures related to evaluation of the process of achieving improvement and revision of approach.	**10 Points**
(e)	Applicant provides evidence that the changes envisioned will mitigate the problem. Describe any evidence that supports the likelihood that the intervention will be successful. This initiative does not support research on human subjects: each intervention tested needs to have adequate underlying evidence that it is likely to yield an improvement.	**10 Points**
(f)	Sustainability and Spread – Describe how the applicant plans to sustain and spread the improvement developed during the period of this grant. These should be concrete and plausible: claims to sustain the work through appropriations or future philanthropy will not generally be persuasive.	**10 Points**

Criterion C: Quality Assurance **Total 5 Points**

In this section, the applicant discusses how it will provide quality assurance and program monitoring and evaluation methodology, as it relates to the proposed program's goals and objectives, and discusses activities, staffing/ resources, data collection and its time line.

(a)	The application identifies methods for conducting process evaluation related to the objectives and how the organization will use this information to make changes in the program. For example the applicant provides information on how staff's activities will be monitored and assessed to determine if the program is being implemented as designed.	**5 Points**
	Describe data to be collected providing a rationale on the applicability of the data to the initiative and how it will be used in the course of the grant. Evidence from the data must be timely and sufficient to guide insights that shape the course of the project. Learning what works requires a way to monitor progress; therefore, give the plan for measurement of at least the initial tests and the overall aim.	

Criterion D: Organizational History and Resources — Total 20 Points

In this section, the applicant should describe the overall experience of the organization and team members.

(a)	The applicant describes past experience of the team as it relates to the development and implementation of the proposed initiative.	**10 Points**
(b)	The applicant describes how the program will be managed and the skills and experience of the program staff and/or team members. The applicant includes information on the roles and responsibilities of the proposed program staff and administrative staff and the staff's skills and experience related to providing and improving services to the target population.	**10 Points**

Criterion E: Budget Justification — NOT SCORED

In this section the applicant provides a detailed description of its budget needs and the type and number of staff it needs to successfully provide the proposed activities. Provide details of budget for each activity. Demonstrate how the operating costs will support the activities and objectives it proposed. **NOTE:** CHA may not approve or fund all proposed activities or expenditures. Please include as much detail as possible to support each budget item, and list each cost separately when possible.

E-1	The applicant's proposed budget is reasonable and realistic.	**Not Scored**
E-2	The resources and personnel proposed are sufficient to achieve the objectives of the proposed program Example: The applicant describes what its budget and staffing needs are. Specifics of how it plans to spend funds. Provide a description for each job, including job title, function, general duties, and activities, the rate of	**Not Scored**

	pay and whether it is hourly or salary, and how much time will be spent by each staff person on the program activities (give this in a percentage, i.e., 50% of time spent on data collection). If known, include the names, titles, and resumes of each person working on the program including staff members and consultants. If staff is not yet known, the applicant should discuss how it plans to recruit these individuals.	

Decision on Awards

The recommendations of the review panel are advisory only and are not binding. DOH/CHA will make recommendations to the Director of DOH who will weigh the results of the review panel against other internal and external factors in making the final funding determinations.

SECTION VIII - APPLICATION FORMAT

Applicants are required to follow the format listed below and each application submitted and must contain the following information. The core application (Sections 1-4) can not exceed 25 pages double spaced.

SECTION / DOCUMENT	PAGE LIMITS
Official Transmittal Letter – signed by person authorized to commit the organization	Not counted in page total
Applicant Organization profile (See Attachment A)	Not counted in page total
Table of Contents	
1 – Knowledge and Understanding of the Problem	Counts in limit
2 – Theoretical and Technical Approach to of Project	Counts in limit
• **Aim**	Counts in limit
• **Team(s)**	Counts in limit
• **Methodology including data to monitor progress**	Counts in limit
• **Work plan brief overview (see below)**	Counts in limit
• **Evidence of Effectiveness of initial changes to test**	Counts in limit
• **Sustainability and Spread**	Counts in limit
3. – Monitoring & Evaluation Procedures - Quality Assurance	Counts in limit
• **Process Evaluation**	Counts in limit
• **Data Collection and Utility**	Counts in limit
4. – Organizational History and Resources	Counts in limit
• Experience in implementing this type of initiative	Counts in limit

• Experience of staff or team in implementing this type of initiative	Counts in limit
Certifications and Assurances (See Attachments B and C)	Not Counted
Driver Diagram (See Attachment H)	Not Counted
Project Work plan (See Attachment D) Please place the workplan in this order, not in the technical application above.	Not Counted
Staffing Plan (See template, Attachment E)	Not Counted
Budget & Budget Justification (See Attachment F)	Not counted
Receipt (See Attachment G)	Not counted in page total
Appendices (Resumes, Organizational Chart, Position Descriptions, Documents concerning past experience and accomplishments)	

Formatting Requirements

The total pages of the core application (Sections 1 -4) cannot exceed 25 double-spaced pages (see chart above). Ensure that the applications are printed single sided, on 8 ½" x 11" white paper. Margins must be at least one (1) inch at the top, bottom, left and right of the paper. Please left-align text. Please use an easily readable serif typeface, such as Times Roman or Arial. The table portions of the application must be submitted in not less than 12 point and 1.0 line spacing. Charts, graphs, footnotes, and budget tables may use a different pitch or size font, not less than 10 pitch or size font. When scanned and/or reproduced in black and white, the graphics must still be clear and readable. All pages must be numbered. **Applications that do not adhere to these requirements will not be reviewed by the panel.**

Description of Application Sections

The purpose and content of each section is described below. Applicants should include all information needed to adequately describe their objectives and plans for services. It is important that applications reflect continuity among the goals and objectives, program design, work plan of activities, and that the budget demonstrates the level of effort required for the proposed services.

Official Transmittal Letter

An individual authorized to submit applications on behalf of the organization must sign a letter transmitting the application to the Chief, Office of Grants Monitoring and Program Evaluation.

Applicant Organization Profile

Each application must include an Applicant Profile, which identifies the applicant, type of organization, and years of experience in similar programs, project service area and the amount of grant funds requested. **See Attachment A.**

Table of Contents

The Table of Contents should list major sections of the application with quick reference page indexing.

Technical Application- Sections 1 – 4 (with Workplan placed in the attachments in the order listed above)

This section should provide the response to the RFA by describing how the applicant and any partners or sub-grants will meet all of the requirements included in that section of the RFA. The applicant is welcome to add any needed information to this format, either within an appropriate section or in an added section, but the need to do this should be unusual.

In the section on organizational experience and resources, the applicant should describe its experience in doing work related to those proposed in response to this RFA. An applicant that represents a coalition can use this section to list the partners and show their role and commitment. An applicant that intends to use sub-grants should characterize the nature of the sub-grant and the strengths of this particular sub-grantee.

The applicant will prepare a work plan using the attached template that includes measurable objectives, timelines and identification of key staff responsible. Key staff should be designated and their CVs or resumes included. Their other commitments should be characterized (by % FTE committed to other work) and their availability for this work affirmed. Key staff may include personnel from collaborating organizations, volunteers, and sub-grantees. If the application involves multiple organizations, this section should also show a plan for the lead organization to monitor progress. This section should also propose a systematic approach to identifying and correcting shortcomings in the proposed performance.

Program Budget and Budget Narrative

Standard budget forms are provided in Attachment F. The budget for this application shall contain detailed, itemized cost information that shows personnel and other direct and indirect costs. Since the exact work and length of work for these projects, and especially for intervention projects, becomes more uncertain into the future, the budget as proposed should reflect a best estimate at this time. Details will be established with the initial and periodic negotiation over the work plan. DOH does not pay for "costs of money" or any other fees associated with financing. Instead, DOH pays ahead for all except the last quarter of funding. The detailed budget narrative shall contain a justification for each category listed in the budget. The narrative should clearly state how the applicant arrived at the budget figures.

Personnel

Salaries and wages for full and part-time project staff should be calculated in the budget section of the grant application. If staff members are being paid from another source of funds, their time on the project should be referred to as donated services (i.e., in-kind, local share and applicant share). Applicants should include any matching requirements, i.e. in-kind employees.

Non-personnel

These costs generally include expenditures for space, rented or donated, and should be comparable to prevailing rents in the surrounding geographic area. Applicants should also add in the cost of utilities and telephone services directly related to grant activities, maintenance services (if essential to the program) and insurance on the facility.

Costs for the rental, lease and purchase of equipment should be included, listing office equipment, desks, copying machines, word processors, etc. Costs for supplies such as paper, stationery, pens, computer diskettes, publications, subscriptions and postage should also be estimated.

All transportation-related expenditures should be included, estimates of staff travel, pre-approved per diem rates, ground transportation, consultant travel costs, employee reimbursement and so forth.

Indirect Costs

Indirect costs are cost that are not readily identifiable with a particular project or activity but are required for operating the organization and conducting the grant-related activities it performs. Indirect costs encompass expenditures for operation and maintenance of building and equipment, depreciation, administrative salaries, general telephone services and general travel and supplies. Please see the note above concerning indirect rules in this RFA.

Certifications and Assurances

Applicants shall provide the information requested in Attachments B and C and return them with the application.

Appendices

This section shall be used to provide technical material, supporting documentation and endorsements and workplan. This must include the Driver Diagram and the Draft Work plan.

Other items may include:

- Annual audits, financial statements and/or tax returns;
- Indication of nonprofit corporation status;
- Roster of the Board of Directors;
- Proposed organizational chart for the project;
- Letters of support or endorsements;
- Staff resumes (required); and
- Planned job descriptions.

ATTACHMENTS

A	**APPLICANT ORGANIZATION PROFILE**
B	**CERTIFICATIONS**
C	**ASSURANCES**
D	**WORKPLAN**
E	**STAFFING PLAN**
F	**BUDGET TABLE**
G	**ORIGINAL RECEIPT**
H	**DRIVER DIAGRAM**
I	**LIST OF ACRONYMS**
J	**LIST OF FUNDED CCI PROJECTS**

ATTACHMENT A

Applicant Profile

Applicant Name: _____

Non-Profit Organization? _____(must be "yes" and documentation of tax status must be attached)

Contact Person:_____

Office Address: _____

_____

Telephone/Fax: _____

E-Mail Address: _____

Organization Description: _____

_____

Application for Section:

[ ] 1. Support: technical and administrative
[ ] 2. Measurement
[ ] 3. Clinical Information Exchange
[ ] 4. Intervention

Title of Application: _____

BUDGET
Funds Requested in First year: $_____

Total Funds Requested (if more than a year) $_____

PERIOD OF PERFORMANCE REQUESTED – from Feb 2009 - ___/___/_____

Major Partners or Sub-grantees at the time of Application (list below, with role)

_____

_____

_____

_____

_____

_____

ATTACHMENT B

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Chief Financial Officer

Certifications Regarding
Lobbying; Debarment, Suspension and Other Responsibility Matters; and Drug-Free Workplace Requirements

Applicants should refer to the regulations cited below to determine the certification to which they are required to attest. Applicants should also review the instructions for certification included in the regulations before completing this form. Signature of this form provides for compliance with certification requirements under 28 CFR Part 69, ‘’New Restrictions on Lobbying” and 28 CFR Part 67, “Government-wide Debarment and Suspension (Non-procurement) and Government-wide Requirements for Drug-Free Workplace (Grants).” The certifications shall be treated as a material representation of fact.

1. LOBBYING

As required by Section 1352, Title 31 of the U.S. Code. And implemented at 28 CFR Part 69, for persons entering into a grant or cooperative agreement over $100,000, as defined at 28 CFR Part 69, the applicant certifies that:

(a) No Federally appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making of any Federal grant, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal grant or cooperative agreement;

(b) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal grant or cooperative agreement, the undersigned shall complete and submit Standard Form – lll, ‘’Disclosure of Lobbying Activities,” in accordance with its instructions;

I, the undersigned shall require that the language of this certification be included in the award documents for all sub awards at all tiers including subgrants, contracts under grants and cooperative agreements, and subcontracts) and that all sub–recipients shall certify and disclose accordingly.

2. Debarment, Suspension, And Other Responsibility Matters (Direct Recipient)

As required by Executive Order 12549, Debarment and Suspension, and implemented at 28 CFR Part 67, for prospective participants in primary covered transactions, as defined at 28 CFR Part 67, Section 67.510—

A. The applicant certifies that it and its principals:

(a) Are not presently debarred, suspended, proposed for debarment, declared ineligible, sentenced to a denial of Federal benefits by a State or Federal court, or voluntarily excluded from covered transactions by any Federal department or agency;

1. Have not within a three-year period preceding this application been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c.) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local with commission of any of the offenses enumerated in paragraph (1)(b) of this certification; and

(d) Have not within a three-year period preceding this application had one or more public transactions (Federal, State, or local) terminated for cause or default; and

2. Where the applicant is unable to certify to any of the statements in this certification, he or she shall attach an explanation to this application.

1. Drug-Free Workplace (Grantees Other Than Individuals)
As required by the Drug Free Workplace Act of 1988, and implemented at 28 CFR Part 67, Subpart F. for grantees, as defined at 28 CFR Part 67 Sections 67.615 and 67.620—

A. The applicant certifies that it will or will continue to provide a drug-free workplace by:

3. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the applicant's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an on-going drug-free awareness program to inform employees about—The dangers of drug abuse in the workplace;
(c) The applicant's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

I Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a);

(d) Notifying the employee in the statement required by paragraph (a) that, as a condition of employment under the grant, the employee will—

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency, in writing, within 10 calendar days after receiving notice under subparagraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title to: Office of Grants Monitoring and Program Evaluation 825 North Capitol St., NW, Room 3137, Washington, DC 20002. Notice shall include the identification number(s) of each effected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under subparagraph (d)(2), with respect to any employee who is so convicted—

(1) Taking appropriate personnel action against such an employee, up to and incising termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(3) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (1), (c), (d), (e), and (f).

B. The applicant may insert in the space provided below the sites) for the performance of work done in connection with the specific grant:

Place of Performance (Street address, city, county, state, zip code)

Drug-Free Workplace (Grantees who are Individuals)

As required by the Drug-Free Workplace Act of 1988, and implemented at 28 CFR Part 67, subpart F, for grantees as defined at 28 CFR Part 67; Sections 67 615 and 67.620—

A. As a condition of the grant, I certify that I will not engage in the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance in conducting any activity with the grant; and

B. If convicted of a criminal drug offense resulting from a violation occurring during the conduct of any grant activity, I will report the conviction, in writing, within 10 calendar days of the conviction, to:

[District of Columbia, Department of Health- Office of Grants Monitoring and Program Evaluation (825 North Capital Street, NE- 3rd Fl, Washington, DC 20002.

As the duly authorized representative of the applications,
I hereby certify that the applicant will comply with the above certifications.

1. Grantee Name and Address

_____ _____

2. Application Number and/or Project Name	3. Grantee IRS/Vendor Number
4. Typed Name and Title of Authorized Representative	
5. Signature	6. Date

ATTACHMENT C ASSURANCES

The applicant hereby assures and certifies compliance with all Federal statutes, regulations, policies, guidelines and requirements, including OMB Circulars No. A-21, A-110, A-122, A-128, A-87; E.O. 12372 and Uniform Administrative Requirements for Grants and Cooperative Agreements - 28 CFR, Part 66, Common Rule, that govern the application, acceptance and use of Federal funds for this federally-assisted project.

Also, the Application assures and certifies that:

1. It possesses legal authority to apply for the grant; that a resolution, motion or similar action has been duly adopted or passed as an official act of The applicant's governing body, authorizing the filing of the application, including all understandings and assurances contained therein, and directing and authorizing the person identified as the official representative of The applicant to act in connection with the application and to provide such additional information as may be required.

2. It will comply with requirements of the provisions of the Uniform Relocation Assistance and Real Property Acquisitions Act of 1970 PL 91-646 which provides for fair and equitable treatment of persons displaced as a result of Federal and federally-assisted programs.

3. It will comply with provisions of Federal law which limit certain political activities of employees of a State or local unit of government whose principal employment is in connection with an activity financed in whole or in part by Federal grants. (5 USC 1501, et. seq.).

4. It will comply with the minimum wage and maximum hour provisions of the Federal Fair Labor Standards Act if applicable.

5. It will establish safeguards to prohibit employees from using their positions for a purpose that is or gives the appearance of being motivated by a desire for private gain for themselves or others, particularly those with whom they have family, business, or other ties.

6. It will give the sponsoring agency of the Comptroller General, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the grant.

7. It will comply with all requirements imposed by the Federal-sponsoring agency concerning special requirements of Law, program requirements, and other administrative requirements.

8. It will insure that the facilities under its ownership, lease or supervision which shall be utilized in the accomplishment of the project are not listed on the Environmental Protection Agency's (EPA), list of Violating Facilities and that it will notify the Federal grantor agency of the receipt of any communication from the Director of the EPA Office of Federal Activities indicating that a facility to be used in the project is under consideration for listing by the EPA.

9. It will comply with the flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973, Public Law 93-234-, 87 Stat. 975, approved December 31, 1976. Section 102(a) requires, on and after March 2, 1975, the purchase of flood insurance in communities where such insurance is available as a condition for the receipt of any Federal financial assistance for construction or acquisition purposes for use in any area

that has been identified by the Secretary of the Department of Housing and Urban Development as an area having special flood hazards. The phrase "Federal Financial Assistance" includes any form of loan, grant, guaranty, insurance payment, rebate, subsidy, disaster assistance loan or grant, or any other form of direct or indirect Federal assistance.

10. It will assist the Federal grantor agency in its compliance with Section 106 of the National Historic Preservation Act of 1966 as amended (16 USC 470), Executive Order 11593, and the Archeological and Historical Preservation Act of 1966 (16 USC 569a-1 et. seq.) By (a) consulting with the State Historic Preservation Officer on the conduct of investigations, as necessary, to identify properties listed in or eligible for inclusion in the National Register of Historic Places that are subject to adverse effects (see 36 CFR Part 800.8) by the activity, and notifying the Federal grantor agency of the existence of any such properties, and by (b) complying with all requirements established by the Federal grantor agency to avoid or mitigate adverse effects upon such properties.

11. It will comply with the provisions of 28 CFR applicable to grants and cooperative agreements including Part 18. Administrative Review Procedure; Part 22, Confidentiality of Identifiable Research and Statistical Information; Part 42, Nondiscrimination/Equal Employment Opportunity Policies and Procedures; Part 61, Procedures for Implementing the National Environmental Policy Act; Part 63, Floodplain Management and Wetland Protection Procedures; and Federal laws or regulations applicable to Federal Assistance Programs.

12. It will comply, and all its contractors will comply with; Title VI of the Civil Rights Act of 1964, as amended; Section 504 of the Rehabilitation Act of 1973, as amended; Subtitle A, Title III of the Americans with Disabilities Act (ADA) (1990); Title IIX of the Education Amendments of 1972 and the Age Discrimination Act of 1975.

13. In the event a Federal or State court or Federal or State administrative agency makes a finding of discrimination after a due process hearing on the grounds of race, color, religion, national origin, sex, or disability against a recipient of funds, the recipient will forward a copy of the finding to the Office for Civil Rights, U.S. Department of Justice.

14. It will provide an Equal Employment Opportunity Program if required to maintain one, where the application is for $500,000 or more.

15. It will comply with the provisions of the Coastal Barrier Resources Act (P.L 97-348), dated October 19, 1982, (16 USC 3501 et. seq.) which prohibits the expenditure of most new Federal funds within the units of the Coastal Barrier Resources System.

_____ _____

Signature Date

Proposed Work Plan

Community Health Administration Grant Application

ATTACHMENT D				
Agency:	**Program Model / Name:**			
Program Area:	**Primary Target Population:**			
GOAL 1:				
Measurable Objectives/Activities:				
Objective #1				
Key activities needed to meet this objective:	Measurement Strategy	Start Date/s:	Testing Completed By:	Key Personnel (Title)
• • • •		• • • •		
Objective #2:				
Key activities needed to meet this objective:		Start Dates:	Testing Completed By:	Key Personnel (Title)
• • • •				
Objective #3:				

Key activities needed to meet this objective:	Measurement Strategy	Start Dates:	Testing Completed By	Key Personnel (Title)
•				
•				
•				
•				

Make additional copies of this page as needed

PAGE ____ of ____

Proposed Staffing Plan

Community Health Administration Grant

ATTACHMENT E

Agency:

Program Area:

Mark "Key Personnel" with an asterisk, *, before their name. CV or resume should be in the Appendix for all people already on staff and designated as Key Personnel.

NAME	POSITION TITLE	FILLED/ VACANT	ANNUAL SALARY	% OF EFFORT	START DATE

Director Signature: _____ Date: _____

BUDGET
Community Health Administration Grant

ATTACHMENT F

Agency: **Date of Submission:**

Service Area: **Project Manager:**
Budget: **Telephone #:**

CATEGORY	ADMINISTRATION	PROGRAM SERVICE
Personnel		
Fringe Benefits		
Travel		
Equipment		
Supplies		
Contractual		
Other		
Subtotal Direct Costs		
Indirect/Overhead		
TOTAL:		

Community Health Administration Grant

RECEIPT

ATTACHMENT G

District of Columbia, Department of Health
Office of Grants Monitoring and Program Evaluation
825 North Capital, NE- 3rd Floor
WASHINGTON, DC 20002

Community Health Administration Grant
CHA-RFA- 11408

THE DISTRICT OF COLUMBIA, DEPARTMENT OF HEALTH
COMMUNITY HEALTH ADMINISTRATION
OFFICE OF GRANTS MONITORING AND PROGRAM EVALUATION
IS IN RECEIPT OF

_____

(Contact Name/Please Print Clearly)

_____

(Organization Name)

_____

(Address, City, State, Zip Code)

_____ _____ _____

(Telephone) **(Fax)** **(E-mail Address)**

_____ **$**_____

(Program Title- If applicable) **(Amount Requested)**

Program Area for which funds are requested in the attached application:
(Check Just one per Application)

[ ] Program-Area One - Support
[ ] Program-Area Two - Measurement
[ ] Program-Area Three – Information Exchange
[ ] Program-Area Four - Intervention

[District of Columbia, Department of Health USE ONLY]
ORIGINAL APPLICATIONAND _____ (NO.) OF COPIES
RECEIVED ON THIS DATE: _____/_____/ 2004
TIME RECEIVED: _____
RECEIVED BY: _____

ATTACHMENT H - A DRIVER DIAGRAM

This exercise is meant to help sharpen the applicant's understanding of the problem they intend to address and to help the reviewers see the problem from the applicant's perspective. Grantees will have the opportunity to keep elaborating their diagram. For present purposes, try to keep your diagram on one page and have it be illuminating of the main effects rather than complete in every detail.

First, the applicant should state the problem that their project intends to improve. This should be stated in a natural and motivating way – something that is important to persons living with chronic conditions (or a specific chronic condition) in DC.

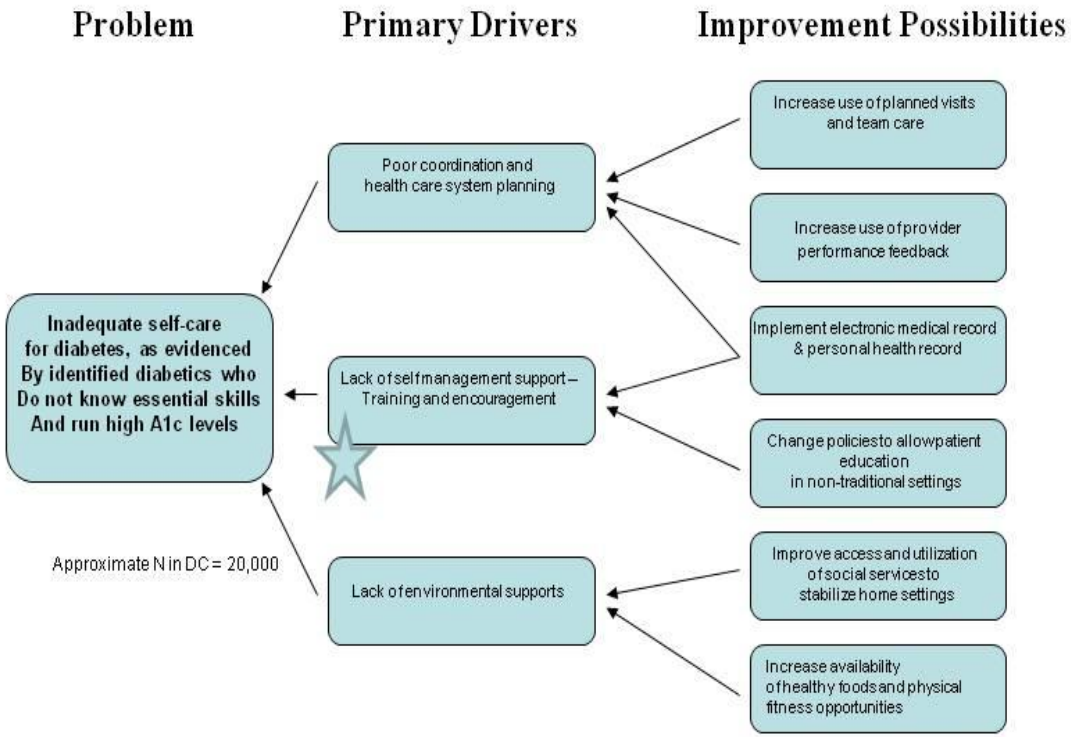
Then, the applicant should consider why this problem is being kept in place – what "drives" it to be there. Problems do not generally happen by happenstance – in general, they are kept in place by discernible forces. There are always multiple ways to classify the forces, so use one that makes sense to the applicant team. Be sure to include the main "drivers" that sustain the problem.

Then, add the column on possible interventions. In your application and workplan, you will be quite specific about exactly how the first couple of interventions will be implemented. Here, you can use more general terms. What sorts of changes would weaken or alter the drivers so that the problem improves?

When you have done this, go back and add two elements: the approximate number of people affected by the problem that live in DC, and an asterisk beside the drivers that your application is likely to address.

Here is a simple example.

Sample Driver Diagram



ATTACHMENT I List of Commonly Used Acronyms

Acronym	Description	Useful Reference Web Site
24/7	24 hours per day, seven days per week	
BCCD	Bureau of Cancer and Chronic Disease	http://doh.dc.gov/doh/site/default.asp- click on administrations and then programs
BRFSS	Behavioral Risk Factor Surveillance System	www.cdc.gov
CCI	Chronic Care Initiative	http://doh.dc.gov/doh/site/default.asp
CCM	Chronic Care Model	http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2
CDK	Cardiovascular Diseases, Diabetes and Kidney Diseases	http://doh.dc.gov/doh/site/default.asp
CFR	Code of Federal Regulations	http://www.gpoaccess.gov/cfr/index.html
CHA	Community Health Administration	http://doh.dc.gov/doh/site/default.asp- click on administrations
CMS	Center for Medicare and Medicaid Services	http://www.cms.hhs.gov/
COPD	Chronic Obstructive Pulmonary Disease	
CQI	Continuous Quality Improvement	http://www.ihi.org/ihi
CVs	Curriculum Vitae	
DOH	Department of Health	http://doh.dc.gov/doh/site/default.asp

Acronym	Description	Useful Reference Web Site
DPCP	Diabetes Prevention and Control Program	http://doh.dc.gov/doh/site/default.asp- click on special programs
ER	Emergency Room	
ESRD	End Stage Renal Disease	http://www.esrdnet5.org/
HIE	Health Information Exchange	
HIPPA	Health Insurance Portability and Accountability Act	http://www.hipaa.org/
HIT	Health Information Technology	
IRB	Institutional Review Board	http://www.annals.org/cgi/reprint/146/9/666.pdf
IT	Information Technology	
MIPPA	Medicare Improvements for Patients and Providers Act, 2008	www.cms.gov
MOU	Memorandum of Understanding	
NCA RHIO	National Capitol Regional Health Information Exchange	http://www.dcpca.org/
RFA	Request for Application	
SOW	Statement of Work	

ATTACHMENT J

ATTACHMENT I - FIRST CYCLE
CHRONIC CARE INITIATIVE GRANTEES – INTERVENTION PROJECTS

Grantee & Key Contact	Target Diseases	Geographic Target Area	Target Population	Key Activities
Unity Health Care 1220 12th Street, SE Washington, DC 20020 202-715-7900 Contact Person: Dr. Aysha Corbett Deputy Chief Medical Officer and Vice President for Quality Improvement (202) 715-7911 acorbett@unityhealthcare.org Karin Werner Vice President Grants Management (202) 715-7950 kwerner@unityhealthcare.org **Medical Home Transitions**	All 6 CCI conditions	citywide	Unity patients with 6 CCI conditions	Obtain real-time notice of admission and discharges. Obtain and give necessary clinical information. Contact these patients <1 week for follow-up. Provide post ED/hosp visit with PCP <1 week. Improving care coordination in order to decrease ED visits by 10%, and rehosp's by 10% Provide self-care and self-monitoring visits with patients following discharge from ED or hospitalization(s)
Whitman-Walker Clinic 1701 14th Street, NW WDC 20009 (202) 797-4410 Contact Person: J. Goforth, Director of medical Adherence and Community Health (202) 745-6118, jgoforth@wwc.org Naseema Shafi, Director of Compliance (202) 797-3572 nshafi@wwc.org	CVD, diabetes, kidney disease, and/or obesity/ being overweight	Citywide	Enrolled patients living with HIV who have co-diagnoses of CVD, diabetes, kidney disease, and/or obesity	Implement nurse-based medical adherence case management using Guiding Care system, in order to: a. Lower blood pressure in 40% of patients with CVD; b. Have 75% of diabetic patients with controlled blood glucose levels; c. Test 80% of diabetic and/or kidney disease patients yearly for proper kidney functioning; and d. Have 50% of obese/overweight patients lose one-half of targeted weight loss.

WWC CCI Case Management				
George Washington University Medical Faculty Associates 2021 K St. N.W. Suite 800, WDC 20006 Contact Person: Dr. Eric Goplerud Project Director Goplerud@GWU.edu Richard Katz, MD Director of Division of Cardiology (202) 741-2323 rkatz@mfa.gwu.edu **Chronic Care Initiative in Mental Health**	Chronic diseases targeted by the overall CCI (CVD, kidney disease, diabetes, and obesity	Citywide	Seriously Mentally Ill (SMI) adults	Improve health status of SMI adults by: a. Reducing hospitalizations by 15%; b. Reducing emergency dep't (ED) visits by 15%; c. Increasing by 20% the number of visits with primary care providers; d. Increasing by 20% the number of patients with recent blood pressure tests, lipid profiles, and blood glucose levels To be accomplished by developing a risk assessment and chronic disease management program for SMI adults in partnership with local MH care providers and other stakeholders, and by instituting common billing system to capture financial resources and cover costs.
George Washington University Medical Faculty Associates 2150 Pennsylvania Ave., N.W. Suite 4-417, WDC 20037 Contact Person: Dr. Richard Katz Director of Division of Cardiology (202) 741-2323 rkatz@mfa.gwu.edu **Cell Phone Intervention**	Diabetes	Wards 1, 2, 4, and 7	Diabetes patients at 2 community-based clinics (Chartered Family Health Clinic, and Howard Univ. Diabetes Clinic)	Reduce ED visits and hospitalizations by 50% within two years, using cell phone networking software and technologies that connect nurse case managers to patients and electronic medical records. Initial focus will be on stabilizing blood glucose levels, to be followed by focus on reducing CVD. Other aims include increasing by 50% the number of patients with chronic disease indicators (BP, Alc, and LDL) at manageable levels, and reduction of average Alc levels in overall patient population.
Catholic Charities' Spanish Catholic Center 1618 Monroe Street, NW WDC 20010 Contact Person: Dr. Marguerite Duane	Diabetes, hypertension, and CVD	Citywide	Latinos	Develop an individualized evidence-based care plan for 90% of patients being seen for diabetes, hypertension, and CVD, resulting in self management goals for 90% and 70% of such patients experiencing reaching desired BP and LDL levels.

Medical Director (202) 939-2414 Dr.Duane@CatholicCharitiesDC,org **Improve Chronic Disease Care for Latinos**				
La Clinica del Pueblo 2831 15th Street, NW, Washington, DC 20009 (202) 462-4788 Contact Person: Isabel Van Isschot Director of Interpretation Extension 261 iisschot@lcdp.org **Interpretation Language Access Education**	Cardiovascular Disease (CVD)	Citywide	Limited English Proficient (LEP) Latinos who require translation services during medical care	Reduce the burden of CVD by: a. Improving the capacity of clinics and hospitals to provide culturally competent translation services by training interpreters; b. Providing translation services for LEP Latinos who are underinsured; c. Developing a financially viable business model for local medical interpretation services; and d. Investigating new technologies for medical interpretation services
Howard University Hospital 2041 Georgia Ave, NW, WDC 20060 Contact Person: Dr. Gail Nunlee-Bland 2041 Georgia Ave., NW Washington, DC 20060 (202) 865- 4758 gnunlee-bland@howard.edu **Diabetes Self-Management Education**	Diabetes	Wards 1, 4, and 8	Patients newly-diagnosed with diabetes	In partnership with two community-based clinics, improve patient outcomes with regard to diabetes by means of a Diabetes Self-Management Education Program, expanded use of health information dissemination technologies, increased use of diabetes management protocols by clinicians, and improved coordination of care among health care providers.
Medstar Diabetes Institute, Washington Hospital Center 100 Irving Street, N.W. Suite 4107, WDC 20010 Contact Person: Gretchen Youssef, MS, RD. CDE	Diabetes	Wards 4, 5, 7 & 8	Persons living with or at risk for diabetes because of hypertension, or being obese or overweight.	Through a coalition of affiliated organi-zations (STEP-DC), identify persons at risk for various chronic diseases and refer into STEP-DC's network for primary and secondary prevention services. Further, the grantee will work with STEP-DC members to institute clinical and community-based changes that improve health outcomes for patients

877-7772 Gretchen.a.youssef@medstar.net **<u>CDK Management Project</u>**				served. Specific objectives are: a. Optimizing reimbursement for diabetes and related disease self-management programs; b. Establishing and supporting a city-wide network of diabetes, CVD, and kidney disease care providers; and c. Implementing methods across STEF-DC to screen for diabetes, pre-diabetes, and related conditions and refer newly-identified patients to relevant providers.
Medstar Diabetes Institute, Washington Hospital Center 100 Irving St. N.W. Suite 4114, WDC 20010 Contact Person: Carine Nassar, MS, RD,CDE (202) 877-0351 carine.m.nassar@medstar.net **<u>Reduce ED Visits Project</u>**	Diabetes	Citywide	Patients who present at local EDs with uncontrolled diabetes	Expand a previously-funded pilot project (involving two local EDs) which reduced uncontrolled diabetes involving: a. Implementation of a medication management, education, and process protocol for use with patients; b. Development of a diabetes education program with primary care providers; c. Expansion of the project to include between 4-6 additional EDs; and d. Develop a plan for a similar CHF program in the near future.